THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

October 17, 2002

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director of Health Services and Chief Medical Officer

Marvin J. Southard, D.S.W.
Director of Mental Health

SUBJECT: **GOLDEN STATE HEALTH CARE CENTERS, INC.**

On June 25, 2002 your Board approved the Department of Mental Health's (DMH) revised recommendation to renew agreements with Golden State Health Centers, Inc. On a motion by Supervisor Yaroslavsky, you instructed the Director of DMH in concert with the Department of Health Services and other appropriate agencies to assess quality of care, workplace safety, and neighborhood security issues of Golden State Health Care Centers, Inc. and report back to the Board in 120 days with recommendations concerning these matters and the appropriate term of the agreement at the end of the six-month extension period.

This is to provide you with the results of these assessments. DHS and DMH each assessed issues within their purview.

Background

Golden State Health Care Centers, Inc. operates two specialized health care centers, the Foothill Health & Rehabilitation Center ("Foothill") and the Sylmar Health and Rehabilitation Center ("Sylmar"). Both are licensed as skilled nursing facilities (SNF's) with Special Treatment Program, a sub-classification entailing unique treatment guidelines consistent with the centers' special patient population of severely and persistently mentally ill adults.

DMH has contracts for the care of mental health patients at these facilities. When the contract renewals were considered in June 2002, SEIU, Local 343-B provided information to your Board about previous health inspections at the facilities.

DHS Health Facilities Division(HFD)

HFD does annual surveys of both facilities. The most recent survey of Foothill occurred in June of this year. Sylmar was reviewed in October 2001 and will be reviewed again in late 2002. The written reports of the most recent annual reviews have been used in preparing this document. In addition to regular annual surveys, HFD inspectors respond to individual complaints and allegations with unannounced inspections. In the case of the Golden State Health Centers, HFD conducted complaint inspections at both facilities in response to letters to DHS in July and August of this year from Ira Yampolsky, SEIU, Local 434-B's research director. Reports of these inspections were also used in the preparation of this report. (HFD staff investigated only those allegations regarding Sylmar within their jurisdiction.)

Grading System

In its annual surveys, HFD uses a federal grading system which indicates, using letters of the alphabet, the seriousness of licensing and certification deficiencies. Letters extend from A through K, in ascending order of acuity. The grading system also indicates the extent to which a violation results in harm to a patient, ranging from "less than minimal potential for harm", "minimal potential for harm," "more than minimal" up to "actual harm". In addition, a comment of "isolated" indicates a one-time event; "not isolated" indicates a trend, either in number of occurences or number of residents affected.

Annual Surveys: Foothill Health & Rehabilitation Center (August 2001, June 2002)

The annual survey of August 2001 identified the following:

5 level " B" deficiencies, not isolated, of minimal potential for harm.
5 level "D"deficiencies, isolated, with more than minimal potential for harm.
4 level "E" deficiencies, not isolated, with more than minimal potential for harm.

The annual survey of June 2002 identified the following:

10 level "D" deficiencies, isolated, with more than minimal potential for harm.
3 level "E" deficiencies, not isolated, with more than minimal potential for harm

None of these deficiencies resulted in harm to any patients. They all occurred at the low end of the acuity grid and included such findings as failure to provide for private closet space, failure to provide for hygiene needs which resulted in pervasive body odor in the facility, and an insect infestation in a patient's room. A complete list and description of all deficiencies and violations summarized here is in **Appendix I, Summary of Compliance History**.

Complaint Investigations: Foothill

Six unannounced inspections between September 2001 and August 2002 revealed six violations of Title 22, California Code of Regulations, including a Class "B" citation and fine and a Special Treatment Program & Patient Care Policy and Procedures Class "B" Citation for failure to protect a resident from sexual assault by another resident. The $1000 fine was trebled because it was a repeat violation. Foothill was also cited for failure to maintain required nursing staffing ratio on 3 out of 8 days reviewed. The sexual assault took place on one of these days.
Of particular concern is HFD's citation for violation of Title 22, California Code of Regulations regarding Foothill's failure to appoint or hire a registered nurse (RN) as Nursing Director. (Foothill had appointed a licensed vocational nurse (LVN) as acting director while they were recruiting an RN for the position. HFD inspectors pointed out that for a facility with this number (204) of gravely mentally ill patients, a registered nurse is required to adequately administer the facility, make nursing assessments of the patients, and to be accountable for the welfare of patients and staff. Foothill hired an RN as Nursing Director on October 15.)

Annual Survey: Sylmar Health Care and Rehabilitation Center (October 2001)

1 level "B" deficiency, not isolated, with minimal potential for harm.
6 level "D" deficiencies, isolated, with more than minimal potential for harm.
1 level "E" deficiency, not isolated, with more than minimal potential for harm.

Complaint Investigations: Sylmar

Four unannounced inspections between December 2001 and August 2002 identified 8 violations of Title 22, California Code of Regulations, including a Class "B" Citation on September 16, 2002 with a fine of $900 which was tripled because it was a repeat violation. Three of the deficiencies cited were related to allegations in Mr. Yampolsky's letters: 1) no registered nurse on duty on August 29, 2002 for one 12-hour shift; 2) a patient sustained a self-inflicted cut (for which medical care was not required) to his arm from a shower hook; and 3) the clean linen supply was low on towels. HFD staff could not substantiate Mr. Yampolsky's other allegations.

DMH's Review

On July 9 and 10 of this year, a Patients Rights Team of 11 staff from DMH conducted a site review at Foothill. The site review consisted of a review of medical records, of selected policies and procedures, of the physical plant, and interviews with 20 patients. The complete report of this review is attached as **Appendix II**. Based on their findings, the DMH team did not recommend further action.

Analysis and Recommendation

It is obvious that neither Foothill nor Sylmar is problem-free. It is troubling as well that problems, especially in the area of staffing and supervision, show no improvement over the past year. Both facilities also have more deficiencies than the national average for all skilled nursing facilities, although that average includes all SNF's, not just facilities like Foothill and Sylmar which have the Special Treatment Program classification. (No national figures for these types of facilities exist because STP facilities are quite rare.)

However, given the nature of the morbidity of Golden State's patients, most of whom according to HFD staff demonstrate poor impulse control and extreme sexual acting out behaviors, we do not find enough serious violations in HFD's reports to recommend against continuing to contract with Golden State Health Care, Inc. to provide services for this extremely challenging group of patients.

We must, however, continue to monitor the facilities closely, especially regarding staffing issues. Failure over the next year to improve in these areas could result in a future recommendation from HFD to withdraw certification on this basis.

Based on these findings, DMH will recommend that your Board extend the contracts with Golden State through June 30, 2003.

If you have any questions or need more information, please let us know.

TLG: MJS:bp
207:008

Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, BOS
SEIU, Local 343-B
Golden State Health Care Centers, Inc.

ATTACHMENT I

SUMMARY OF COMPLIANCE HISTORY
FROM 8/1/01 TO 9/27/02

FOOTHILL HEALTH AND REHABILITATION CENTER
&
SYLMAR HEALTH AND REHABILITAION CENTER

FOOTHILL HEALTH AND REHABILITATION CENTER

Survey of August 2001 identified the following:

TYPE "B" LEVEL DEFICIENCY - Five deficiencies that were of minimal potential for harm and the identified violations involved more than one resident and/or occurrence.

- F241 – Failed to provide dignity for four residents by staff speaking in foreign languages that residents do not understand while providing direct care to the residents
- F255 – Failed to provide private closet space in each room for three residents.
- F278 – Failed to complete the minimum data set as required for two residents.
- F283 – Failed to complete the discharge summary for one resident transferred to an acute hospital.
- F286 – Failed to maintain, for 15 months, completed assessments for two residents.

TYPE "D" LEVEL DEFICIENCY - Five deficiencies that were more than minimal potential for harm and the identified violations involved only one resident and/or occurrence.

- F246 – Accommodation of residents needs and preferences in that a resident paid for a piece of equipment that facility never provided.
- F316 – Failed to provide a bladder retraining program at time of decline in bladder continence for one resident.
- F323 – Facility failed to ensure resident environment was free of accident hazards in that exposed nails and scissors were not stored in a secured manner.
- F441 – Failed to ensure a TB skin test for one resident was done and failed to store resident toothbrushes in separate containers for residents.
- F500 – Failed to ensure that the contract laboratory service had a written agreement requiring the reporting of abnormal lab findings within a specific time frame.

TYPE "E" LEVEL DEFICIENCY – Four deficiencies that were more than minimal potential for harm and the identified violations involved more than one resident and/or occurrence.

F166 – Facility failed to resolve resident grievances at Resident council meeting request for newspaper and more chairs for group activities.

F253 – Housekeeping and maintenance services in that there was peeling in residents' rooms no hot water to two resident bathrooms an insect infestation in one resident's room and etc noting some 9 areas of maintenance concerns.

F505 – Prompt notification to the attending physician of abnormal laboratory results for 4 residents.

F518 – Failed to adequately train employees in emergency procedures and drills in that staff were not aware of the combination to the locks used to enclose fire extinguishers.

72377 (b), Title 22, CCR facility failed to provide sublingual or inhalation emergency drugs in single sealed containers.

72651 (b), Title 22, CCR facility failed to ensure waste line for two food equipment machines.

The average number of deficiencies per survey for the state is 8.37, for CMS Region IX, which includes California, Hawaii, Arizona, Nevada, Washington and Guam is 8.41 and for the nation it is 5.21. This survey resulted in 16 deficiencies; however, none resulted in actual harm to the residents.

Survey of June 20, 2002 identified the following:

TYPE "D" LEVEL DEFICIENCY - Ten deficiencies that were more than minimal potential for harm and the identified violations involved only one resident and/or occurrence.

F157 – Failure to notify attending physician of a resident's refusal to have lab work performed.

F246 – Failed to accommodate resident needs and preferences in that two of three resident washing machines were broken.

F272 –Failed to provide a comprehensive Assessment for three residents relative to nutritional problems.

F279 – Failure to develop a care plan for three residents with weight problems and non-compliance difficulties.

F309 – Failure to provide necessary care and services to reach the residents highest level of well being for one resident needing pain management control.
F325 – Failed to maintain four resident's nutritional status by not implementing the dietitian's recommendation for weight reduction.
F425 – Failure to notify the pharmacist and replace drugs from the emergency kit within 72 hours.
F432 – Internal and external drugs not stored separately in one nursing unit.
F502 – Failure to obtain laboratory results ordered by the attending physician for two residents.
72523 (a) Title 22, CCR failure to establish policies and procedure relative to nutritional monitoring of residents who utilize the canteen for resident on weight reduction diets and for diabetic residents.

TYPE "E" LEVEL DEFICIENCY – Three deficiencies that were more than minimal potential for harm and the identified violations involved more than one resident and/or occurrence.

F226 – Facility failed to develop abuse policy that included all required components of abuse prevention and prohibition.
F252 – Failure to provide a clean & comfortable environment in that significant body odor was noted throughout the facility partly due to an ineffective air conditioning system.
F278 – Failure to reassess one resident's protein status and to complete the assessment for five of twenty-seven residents.
F429 - Failure to develop a system to report drug irregularities to the attending physician and the director of nurses
F445 – Failed to ensure that soiled linens were stored in an approved manner and not on the resident's floor.
F465 – Failure to maintain comfortable water temperatures in seven resident rooms/areas.

The average number of deficiencies per survey for the state is 8.37, for CMS Region IX, which includes California, Hawaii, Arizona, Nevada, Washington and Guam is 8.41 and for the nation it is 5.21. This survey resulted in 16 deficiencies; however, none resulted in actual harm to the residents.

COMPLAINT INVESTIGATIONS:

9/26/2001 Violation of Section 72523 (a) Title 22,of California Code of Regulations and deficiency issued for not implementing policies and procedures to ensure patient related goals and objectives are achieved. Patient cut his wrist with a razor while under the supervision of facility staff member.

12/8/2001 Violation of Section 72523 (a)(b) Title 22, of California Code of Regulations and deficiency issued for not following the facility's policy and procedure relating to employee accused of sexual assault on a patient.

3/25/2002 Violation of Sections 72315(b) & 72323 (a) Title 22, California Code of Regulations and class "B" Citation issued and assessed at $400.00 for failure to follow their policies and procedures regarding verbal abuse of a patient by a staff member.

8/5/2002 Violation of Sections 72455 &, 72523 (a), Title 22 California Code of Regulations – Special Treatment Program & Patient Care Policy and Procedures Class B Citation issued on 9/26/02 The facility failed to protect a 33-year-old female resident from being sexually abused by a 41-year-old male patient. She stated this occurred over a period of time however she only reported the last incident that occurred on 8/11/02. She stated she cried out for help but no one came; staffing was under the required minimum for that day (see 72329 deficiency). The police took the male resident to jail. The Department issues a Class B citation with a civil money penalty of $1,000, which was trebled to $3000 because this was a repeat violation from another incident that had occurred within the last 13 months.

8/5/2002 Violation of Section 72329 (f) (1) (B) Title 22 California Code of Regulations – Nursing Services, Staff
As a Special Treatment Program, the facility is to staff with a minimum of 2.3 nursing hours per patient day which is calculated on a 24-hour basis. The staffing was reviewed from 8/4/02 through 8/11/01. The facility did not meet the 2.3 hours on three days: 8/3/02 (2.0 hours), 8/4/02 (2.2 hours), and 8/11/02 (2.2 hours). On 8/11/02 the female resident that had been raped stated she had called out for help and no one came.

8/6/2002 Violation of Section 72327 (a) Title 22 California Code of Regulations – Nursing Services, Director of Nursing
The regulation states that the Director of Nursing shall be a registered nurse. The facility is using a Licensed Vocational Nurse (LVN), instead of a Registered Nurse (RN), as the acting director while the facility recruits for a permanent director. This facility is licensed for 204 residents. According to the Board of Registered Nursing the LVN can not do a nursing assessment only the RN; the LVN can collect data, but must give that data to the RN for a nursing assessment. The Director of Nursing Services has administrative authority, responsibility and accountability for all the nursing services within the facility.

SYLMAR HEALTH AND REHABILITAION CENTER

Survey of October 30, 2001 identified the following:

TYPE "B" LEVEL DEFICIENCY - Five deficiencies that were of minimal potential for harm and the identified violations involved more than one resident and/or occurrence.

F500 – Failure to receive lab results for five residents from a contract outside laboratory in accordance with the contract time frames.

TYPE "D" LEVEL DEFICIENCY - Ten deficiencies that were more than minimal potential for harm and the identified violations involved only one resident and/or occurrence.

F253 – Failure to maintain the resident care equipment in operating condition i.e. mattress covers torn, shower light non-operational and torn window screens in 2 rooms.

F309 – Failure of the facility to provide one resident with anti-seizure medication as prescribed.

F325 – Failure to maintain the nutritional status for three residents. Two residents were not monitored for weight gain and one resident had an unplanned weight loss.

F411 – Failure to meet the dental needs of two residents. One resident required dentures and the other resident had an order for a dental examination.

F430 – Failure to document a drug regimen irregularity, identified by the pharmacist, to the physician.

F441 – Failure to ensure that two residents had been screened for HIV virus per facility policy and procedure.

TYPE "E" LEVEL DEFICIENCY – Three deficiencies that were more than minimal potential for harm and the identified violations involved more than one resident and/or occurrence.

F326 – Facility failed to assure that diabetic residents and residents on low calorie diets for obesity receive therapeutic snacks.

The average number of deficiencies per survey for the state is 8.37, for CMS Region IX, which includes California, Hawaii, Arizona, Nevada, Washington and Guam is 8.41 and for the nation it is 5.21. This survey resulted in 8 deficiencies; however, none resulted in actual harm to the residents.

COMPLAINT INVESTIGATIONS:

12/24/2001 Violation of Section 72523 (a) Title 22, California Code of Regulations and deficiency issued for not implementing abuse prevention policy and procedure, to protect a resident during an investigation of an allegation of sexual abuse. Facility failed to remove the accused staff member from resident care during the investigation.

3/28/2002 Violation of Section 72315 (b) Title 22, California Code of Regulations and a class "B" Citation issued to the licensee and assessed at $900.00 for failing to ensure that a patient was not subjected to physical abuse in that a staff member hit a mentally retarded resident on the back of the head and pulled his hair.

8/27/2002 Violation of Section 72329(d) Title 22, California Code of Regulations and a deficiency issued for failing to have a registered nurse on duty at all times. There was no registered nurse on duty on the night shift for station 1 and station 2.

Violation of Section 72311(a)(2) Title 22, California Code of Regulations and a deficiency issued for failing to implement one patient's care plan by removing any objects that would enable the patient to harm himself. Patient was found with a self-inflicted cut on his left forearm and a curtain hook in his hand.

Violation of Section 72625(g) Title 22, California Code of Regulations and a deficiency issued for failing to provide a supply of clean towels to assist the care needs of the patients. The residents also complained that they had to use bed sheets to dry themselves.

8/29/2002 Violation of Section72315 (b)- Title 22 California Code of Regulation - Nursing Service, Patient Rights and a Class B Citation issued 9/16/02. While investigating this complaint on 8/29/02 the facility informed the evaluator that an abuse incident had occurred on 8/28/02 between a staff nurse and one of their patients. The staff nurse had denied one resident the use of a hand held nebulizer. This resident had a diagnosis of a lung disease that required the periodic use of this nebulizer when he became short of breath. The nurse stated she was also dealing with another crisis situation and became angry when he insisted of this medication. Things escalated and she responded inappropriately using foul language. The resident felt that the nurse was trying to punish him because he smoked. Medically the patient did not suffer untoward effects; however, the Department issued a Class B citation with a civil money penalty of $900, which was trebled to $2,700 because this was a repeat violation from another incident that had occurred within the last 13 months. The Department issued this citation because the resident was not treated with dignity and respect when he was physically abused by not giving him his medication as ordered by the physician for shortness of breath and verbally abused by responding to him using foul language.

Violation of Section 72329 (d) Title 22 California Code of Regulation - Nursing Service, Staffing and a deficiency was issued. On 8/29/02 the night shift did not have a registered nurse on duty as required by law. The facility had 199 residents residing in the facility. The residents had also voiced concerns for their safety and requested more supervision. The staff was concerned with staffing issues and brought this to the Department's attention in the complaint.

Violation of Section 72311 (a) (2) Title 22 California Code of Regulations, Nursing Services, and a deficiency was issued. One resident with a history of suicide at another facility had a care plan to physically separate from him any objects that would enable him to harm himself. On March 29, 2002 the resident was found in the bathroom with a fresh cut to his forearm from a curtain hook that had not been removed from his room. The staff had brought this to the Departments attention in the complaint, which was verified. The resident did not require medical treatment for the cut.

Compliance history Foothill & Sylmar Rehab.

ATTACHMENT II

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

DAVID MEYER
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

BOARD OF SUPERVISORS
GLORIA MOLINA
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DEPARTMENT OF MENTAL HEALTH

http://dmh.co.la.ca.us

Reply To: Patients' Rights Office
(213) 738-4888
Fax: (213) 365-2481

August 8, 2002

Ray Shaughnessy
Administrator
Foothill Health and Rehabilitation Center
12260 Foothill Blvd.
Sylmar, California 91342

Dear Mr. Shaughnessy:

On July 9 & 10, 2002 the Patients' Rights Survey Team, Elena Extra and Jo Martinetti conducted a Site Review at. Foothill Health and Rehabilitation Center. Attached is a summary of their findings and related recommendations.

Based on their findings and the understanding that Foothill Health and Rehabilitation Center will be complying with the recommendations made in the report, we are not recommending further action. If our staff determines that violations continue to occur in the identified areas, a plan of correction with a corresponding follow-up review will be required. If you have any questions please feel free to call me at (213) 738-2524.

On behalf of the Survey Team, I wish to thank you and your staff for the assistance provided during the survey

Sincerely,

Ellen Satkin
Supervising Patients' Rights Advocate

Attachment (1)

c: Marvin J. Southard, DSW, Director
David Meyer, Chief Deputy Director
Roderick Shaner, MD, Medical Director
Tony Belize, PhD, Deputy Director
Mary Marx, Long Term Care Program

DEPARTMENT OF MENTAL HEALTH - PATIENTS' RIGHTS OFFICE

Site Review Survey

Sylmar Health and Rehabilitation Center
12220 Foothill Boulevard
Sylmar, California 91342

I. REVIEW METHODOLOGY

A. **SITE VISIT DATE**: May 7 & 8, 2002

B. **FACILITY DESCRIPTION**:

1. LPS designation status: Skilled Nursing Facility
2. License type: Psychiatric Skilled Nursing Facility (SNF) with a Special Treatment Program (STP)
3. Number of psychiatric beds: 47 IMD and 43 Sub-acute

C. **UNITS & PROGRAMS REVIEWED**:
Survey encompassed a site tour of 2 units (Station 1 and 2), review of selected policies and procedures , a medical record review, and interviewing 20 patients.

D. **PARTICIPATING STAFF**:

Dolores Mitchell, RN	Director of Nursing
Dan Cleland,	Rehabilitation Program Director
Jennifer Henningfield, LCSW	Social Worker
Rosita Gordon, LVN	Quality Assurance Nurse
Vera Castro,	DMH Mental Health Worker

E. **REVIEWERS**:
Elena F. Extra, Patients' Rights Advocate
Jo Martinetti, Patients' Rights Advocate
Office of Patients' Rights
Department of Mental Health

F. **DOCUMENTS REVIEWED**:

1. Policies, Procedures and Forms:
   - Authorization for Admission
   - Human Sexuality Policy
   - Residents Pass Policy
   - Residents Trust Fund Policy
   - Voluntary Admission Policy
   - Visitation Policy
   - Seclusion and Restraints Policy
   - Residence Pass Policy

2. Patient Records
   a. Chart selection method:
      Reviewers selected closed charts from monthly reports related to Denial of rights and seclusion/restraint,
   b. Period represented by patient charts: May 2002
   c. Chart numbers

231-1	145-2	362-2	212-1	367-1	130-2	5-76-99	336-1
310-1	300-1	341-1	418-1	414-1	345-1	343-1	396-1

DEPARTMENT OF MENTAL HEALTH - PATIENTS' RIGHTS OFFICE

Site Review Survey
Foothill Health and Rehabilitation Center
12260 Foothill Boulevard
Sylmar, California 91342

1. **Methodology**

A. SITE VISIT DATE: July 9 & 10 , 2002

B. FACILITY DESCRIPTION:

1. LPS designation status: Skilled Nursing Facility
2. License type: Psychiatric Skilled Nursing Facility (SNF) with a Special Treatment Program (STP)
3. Number of psychiatric beds: 204

C. UNITS & PROGRAMS REVIEWED:
Survey encompassed a site tour of three units (Station 1, 2, &3), review of selected policies and procedures , a medical record review, and interviewing 18 patients.

D. PARTICIPATING STAFF:

Ray Shaughnessy	Administrator
Barbara Brown	Office Manager
Theresa Drobina	Acting Director of Nursing
Ric Perlstein	Nursing Supervisor
Jason Deibel	Program Director
Karla Brada	Social Service Designee
Jayne Frost	Unit Coordinator
Martin Weiss	Owner
Doug Benson	Director of Social Service
Victoria Banks	Social Worker
Daniel Eldridge	Conrep Program Director

E. REVIEWERS:
Elena F. Extra, Patients' Rights Advocate
Jo Martinetti, Patients' Rights Advocate
Patients' Rights Office
Department of Mental Health

F. DOCUMENTS REVIEWED:

1. Policies, Procedures and Forms:
   - Absence Without Leave
   - Leaving Without Notifying Staff
   - Canteen/ Token Economy
   - Resident Personal Finances
   - Medication Administration
   - Sexual Conduct of Residents
   - Safe Sex Guidelines form
   - Search Process
   - Documentation of Denial of Rights
   - Medical Admission Criteria
   - Assault Precautions
   - Use of Physical Restraint and Time Out
   - Admission Packet
   - New Employee Orientation Packet

   Resident Consent for Medical Treatment form

2. Patient Records

a. Chart selection method:

Reviewers selected closed charts from monthly reports related to Denial of Rights and seclusion/restraints

Randomly from open and closed records. Chart Numbers:

533-1, 453-1, 512-1, 397-1, 374-1, 541-1, 577-1, 593-1, 576-1, 559-1, 430-1, 436-1, 384-2, 419-1, 437-1, 157-4, 232-2, 302-3, 916899, 1216697, 1116597,

II. Survey Focus Area: IMD MEDICAL RECORD REVIEW

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	ADMISSION CRITERIA	
WIC 6002	The application for voluntary treatment is signed by the patient or conservator (private). **4 of the 14 charts reviewed were of patients on private conservatorships. One chart was reviewed of a patient on voluntary status.** **The applications for voluntary treatment were not signed by the private conservators in 3 of the 4 charts reviewed (#916899, 0593-1, 0576-1). The voluntary patient signed the admission papers.**	Ensure that the conservator signs application for voluntary treatment.
	The date of admission is the date of application. **In 3 of the 4 charts reviewed the admission papers were not signed and therefore not dated after the patients' admission (# 0559-1, 0430-1, 0593-1).**	Ensure that the all applications for voluntary treatment are properly signed and dated.
WIC 6002	If the patient is on a **private conservatorship** there is proof that the conservator has power to admit (papers indicating power 6). **2 of the 4 relevant charts had conservatorship papers indicating power 6. The list of powers was ineligible in chart #0593-1. There was no list of powers in chart #916899.**	Ensure that charts of all patients on private conservatorships contain the current conservatorship papers including documentation of powers.

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	If the patient has, a **public guardian** a Detain and Treat or other documentation is present to authorize the current admission. **There were 3 charts reviewed of patients with Public Guardians. One of these was missing Detain and Treat forms or other authorization for current admission (1216697).**	Ensure that there is a Detain and Treat form or other documentation authorizing admission for each patient that has a Public Guardian.
	If, the patient is on a **t-con** there is a Detain and Treat from the public guardian's office. **Staff reported that they did not admit any patients on t-cons in the past year.**	
T.22 72303 (b)(1)	Physician completes a physical examination including a written report within 5 days prior to admission or within 72 hours following admission. **The physical examination including a written report was done within 5 days prior to admission or within 72 hours following admission in all fourteen charts reviewed.**	
T 22 72301 (a)	Physician evaluates the patient as needed and at least every 30 days. **The patients in 10 of the 14 charts reviewed were evaluated appropriately. In 4 charts the evaluations were not done in a timely manner (0541-1, 0577-1, 0576-1, 0559-1).**	Ensure all patients are evaluated by the physician as needed and at least every 30 days.
T 22 72451 (1) (H) (c)	Each patient admitted shall have a **psychological evaluation** and assessment by the appropriate discipline within **45 days** of admission **12 of the 14 charts reviewed evidenced a psychological evaluation completed within 45 days of admission. It was missing in charts #453-1 and 374-1.**	Ensure that all patients have a psychological evaluation within 45 days of admission.
T 22 72433 (b) (1)	**A social work** written assessment is completed within **five days** after admission. **8 of the 14 charts reviewed evidenced a social work written assessment completed within 5 days after admission. In 6 charts (0541-1, 0593-1, 0576-1, 0559-1,453-1, 1216697), the social work assessment was not completed within the required time frame.**	Ensure all social work written assessments are completed within 5 days after admission.
T22 72451 (1) (H) (b)	Each patient admitted shall have an initial evaluation and assessment by facility staff of his medical, nursing dietetic, social and physical needs within **15 days** of admission unless an evaluation has been done by the referring agency within 30 days prior to admission. **Timely initial evaluations and assessments by facility staff were present in all 14 charts reviewed.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	CARE PLANS/TREATMENT PLANS	
T 22 72471 (1)	Initial assessment completed within **7 days** by a licensed nurse **Initial assessments by a licensed nurse were completed within 7 days in all of the 14 charts reviewed.**	
T 22 72471 (2) (a) (b) (c)	Plan for meeting behavioral objectives including • Resources to be used • Frequency of plan review and updating • Persons responsible for carrying out plan **The plan for meeting behavioral objectives was documented in all 14 charts reviewed.**	
T 22 72471 (3)	Written Care plan based on individual needs indicating • care to be given • measurable objectives to be accomplished with time frames • The professional discipline responsible for each element of care **The written care plan based on individual needs was documented in all 14 charts reviewed.**	
T 22 72471 (3)	Care plan reviewed and updated each 90 days **The care plan was updated and reviewed every 90 days in 13 of the 14 charts reviewed. It was missing in chart #0577-1.**	Ensure that the care plan is updated each 90 days.
T 22 72471 (3)(c)	Care plan shall be approved, signed and dated by the attending physician. **The care plan was not approved, signed and dated by the attending physician in 6 of the 14 charts reviewed (0541-1, 0593-1, 0559-1, 533-1, 453-1, 512-1).**	Ensure that a care plan is approved, signed and dated by the attending physician.
T22 <u>72471</u> (3) (e)	Shall be monthly progress notes in the record for each patient, which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patient and the program objectives and the success of the plan. **The monthly progress notes were present in all 14 charts reviewed.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	DISCHARGE PLANNING	
WIC 5622	The chart contains a written aftercare plan. **2 of 14 charts reviewed were closed charts (430-1, 374-1). Both contained a written aftercare plan.**	
	It is dated on or before the date of discharge **The aftercare plan in both closed charts were dated on or before the discharge dates.**	
WIC 5622 (a) (1)	It specifies the nature of the illness and follow-up required **The aftercare plan in the two closed charts specified the nature of the illness and the follow-up required.**	
WIC 5622 (a) (3)	The expected course of recovery **The expected course of recovery was not noted in chart #430-1.**	Ensure that the expected course of recovery is noted in all written aftercare plans.
WIC 5622 (a) (4)	Recommendations regarding treatment t are relevant to the patient's care **Both aftercare plans contained recommendations regarding treatment relevant to the patients' care.**	
WIC 5622 (a) (2)	The aftercare plan, to the extent known, specifies medications, including side effects and dosages. . **The after-care plan in chart #374-1 did not specify the medications including side effects and dosages. Chart # 430-1 was in compliance.**	Ensure that the after-care plan specifies the medications including side effects and dosages.
WIC 5622 (b)	There is evidence that the patient received a copy of the after care plan. **There was no documentation in chart #430-1 that the patient received a copy of the after care plan.**	Ensure that all patients receive copies of the aftercare plan.
WIC 5622 (b)	There is evidence that the patient's guardian or conservator received a copy of the after care plan. **There was no evidence in chart #430-1 that the patient's conservator received a copy of the aftercare plan. The patient in chart # 374-1 not on a conservatorship.**	Ensure that all patients' guardians and/or conservators receive a copy of the aftercare plan.
WIC 5622 (c)	There is evidence that any other person designated by the patient was given a copy of the aftercare form. **In both charts there was no other person designated by the patients to receive a copy of the after-care plan.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	PATIENTS' RIGHTS	
WIC 5325 (i)		
T 9 862 (b) (c)	Each person admitted to a facility shall be personally notified of his rights in writing, in a language he can understand. A notation to that effect shall be entered in the patient's record within 24 hours of admission (handbook). **In 9 of the 14 charts reviewed, there was documentation that patients were notified of their rights in writing. There was no such evidence in 4 charts (0541-1, 0577-1, 0593-1, 0576-1). The patients' rights notification was not dated in chart #374-1, and therefore it was not possible to determine the timeliness of the notification.**	Ensure that all patients are notified in writing of their rights within 24 hours of their admission, and that the rights notifications are dated.
T 9 865.3	Treatment modalities shall not include denial of any right specified in Section 861 **The reviewers did not find any denial of rights based on treatment modalities.**	
WIC 5328.7	**CONSENT FOR RELEASE OF FORMATION**	
WIC 5328.7	The use of the information; **According to facility staff the consent for release of information is obtained on an as needed basis. The consent for the release of information was present in the two discharged charts (430-1, 374-1).**	
WIC 5328.7	The information to be released **The consent for the release of information in charts 0430-1 and 374-1 specified the specific information to be released.**	
WIC 5328.7	The name of the recipient individual or agency; **The consents for the release of information in the abovementioned-discharged charts specified the name of the recipient individual or agency.**	
WIC 5328.7	The name of the person authorizing the release **The consent for the release of information for the abovementioned-discharged charts specified the name of the person authorizing the release.**	
WIC 5328.7	Notice is signed and witnessed by a facility representative. **The notice was signed and witnessed by a facility representative on the consent for the release of information in the abovementioned charts.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	PSYCHIATRIC MEDICATION – VOLUNTARY ADULTS & LPS CONSERVATEES WITH CAPACITY TO CONSENT	
CCR, T.9, 851	As evidenced in the **medical record**: Patient has given **written informed consent** for each class of medication taken (antipsychotic/neuroleptic, lithium/mood stabilizer, antidepressant), **or** there is physician notation that the patient understands and consents, but does not desire to sign the form. **In all 14 charts reviewed, a written informed consent for each class of medications taken was present.**	
T. 9. 851 (a)	Consent **includes:**	
851 (b)	The nature of his/her mental condition. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent once given may be withdrawn by stating such intention to any member of the treating staff **In all 14 charts reviewed, the written informed consent included the nature of his/her mental condition, the reasons for taking such medications including the likelihood of improving or not improving without such medications and that the consent once given may be withdrawn.**	
851 (c)	The reasonable alternative treatments, if any **In all 14 charts reviewed, the written informed consent included the reasonable alternative treatments.**	
851 (d)	The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medication **In all 14 charts reviewed, the written informed consent included the type, range of frequency and amount (including use of PRN orders), method, duration of taking the medications.**	
851 (e)	The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the patient **In all 14 charts reviewed, the written informed consent included the listing of the probable side effects of the drugs known to commonly occur and any particular side effects likely to occur to the patient.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
851 (f)	The possible additional side effects which may occur to patients taking such medication beyond three months **In all 14 charts reviewed, the written informed consent included the possible additional side effects which may occur to the patients taking such medication beyond three months.**	
	Patient was informed of right to accept or refuse psychiatric medication before medication was administered. **In all 14 charts reviewed, the patients were informed of their right to accept or refuse psychiatric medication before medications were administered.**	
	MEDICATION - LPS CONSERVATEES/ T-CONS	
WIC 5358(b)	If the patient is receiving psychiatric medications, consent was provided by the authorized LPS conservator (private). **Consent for psychiatric medications by the private conservators was not documented in 2 of the 4 private conservatorship charts (0593-1, 0576-1).**	Ensure that if a patient is receiving psychotropic medications and is on a conservatorship with powers to medicate, consent to medicate is provided by the authorized LPS conservator.
	There is a signed consent for each class of medications. **There was no signed consent for each class of medications in 2 of the 4 private conservatorship charts reviewed (0593-1 and #0576-1). .**	Ensure that there is a signed consent for each class of medication.
	For patients with Public Guardians, there is a signed Detain and Treat indicating if the conservator has power 8A. **In 3 of the 14 charts reviewed, the patients had Public Guardians (2 from other Counties). Both out of County charts had court papers with documentation of appropriate powers. There was a Detain and Treat form for the Los Angeles County patient (374-1).**	
	Consents are all dated on or before the date of the conservatee's first dose of antipsychotic medication. **In the three charts of patients with Public Guardians, consents were all dated on or before the date of the conservatees' first dose of antipsychotic medications**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	EMERGENCY MEDICATION	
CCR T.9 853	There is documentation that an emergency exists **6 of the 14 charts reviewed indicated that emergency medications were administered. In all 6 cases there was documentation that an emergency existed.**	
CCR, T. 9, 853	Such medication is only that which is required to treat the emergency condition, and is provided in ways that are least restrictive of the personal liberty of the patient. **In all of the abovementioned 6 cases that were administered emergency medications, there was evidence that such medications were required to treat the emergency condition.**	
	RIGHTS DENIALS (other than Seclusion and Restraint) (e.g. clothes, visitors, etc.)	
CCR, T. 9, 865.3	Each denial of a patient's rights is noted in his/her **medical record**, inclusive of 5 charts (436-1,384-2,419-1,437-1,157-4) were reviewed containing patients' rights denials (3 phones and 2 visitors). In all of the five charts reviewed, each denial of patients' rights was noted in the medical record.	
865.3 (1)	The date the right was denied **In all 5 charts, the date the right was denied was noted.**	
865.3 (1)	The time the right was denied **In all of the 5 charts, the time the right was denied was noted.**	
865.3(2)	The specific right denied **In all of the 5 charts, the specific right denied was noted.**	
865.3 (3)	Good cause for denial (documented justification based on the judgment that exercising the right would injure the patient, seriously damage the facility, or seriously infringe on the rights of others; **In all of the 5 charts, the good cause for denial was noted.**	
865.2 (4)	There is no less restrictive way to handle the situation; **In all of the 5 charts, it appeared that there was no less restrictive way to handle the situation.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
865.3 (5)	There is a signature of the professional person authorizing the denial **4 of the 5 charts reviewed contained a signature of the professional person authorizing the denial. One chart (436-1) did not.**	Ensure that all denials include a signature of the professional person authorizing the denial
865.3 (4)	There is documentation and date of review if denial was extended beyond 30 days **One of the 5 charts reviewed did not indicate the length of time the right to make phone calls was denied (437-1). Therefore, it could not be determined if this denial exceeded 30 days. In the remaining 4 charts, the denial of rights did not exceed 30 days.**	Ensure that there is documentation indicating the length of time the right is denied.
CCR, T. 9, 865.5	A right does not continue to be denied a patient when the good cause for its denial no longer exists, e.g., conditions no longer exist, denial no longer the least restrictive means available. **In chart #437-1, it was difficult to determine if a right continued to be denied even when good cause no longer existed and the denial was no longer the least restrictive means available because the length of time of the denial was not documented. The other four charts were in compliance with this standard.**	Ensure that there is documentation indicating the length of time the right is denied and ensure that a right does not continue to be denied when the good cause for its denial no longer exists, if this is not already being done.
CCR, T. 9 866	The denial was reported to the Patients' Rights Office accurately. **In all five charts reviewed, the denial was reported to the Patients' Rights Office accurately.**	
	SECLUSION AND RESTRAINT **Two seclusion and restraint charts were reviewed (232-2 and #302-3). They were identified from the Seclusion and Restraints report the facility submitted to the Patients' Rights Office within the past year.**	
CCR, T. 22, 72319(i)(2)(a).	There shall be no prn orders for behavioral restraints **In the 2 charts reviewed, there were no prn orders for behavioral restraints.**	
CCR, T. 22, 72461(a)).	Order for S/R is signed by MD **In the 2 charts reviewed, the MD signed the order for seclusion/restraints.**	
CCR, T. 22, 72461(a)).	Order written for 24 hours or less **In the 2 charts reviewed, the order was written for 24 hours or less.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	MD gives order for restraint within one hour of application **In the 2 charts reviewed, the MD gave the order for restraints within one hour of application.**	
CCR, T. 22 72461 (a)	MD signs telephone orders within 5 days **In the 2 charts reviewed, the MD signed the telephone order within 5 days.**	
CCR, T. 22, 72457 (a)	Only used as emergency to protect the patient from injury to self or others **In the 2 charts reviewed, the S/R order was used only as an emergency to protect the patient from injury to self and others.**	
CCR, T. 22 72461 (c)	Chart documentation including; Episode leading to the behavior of S/R **In the two charts reviewed, there was sufficient chart documentation including the episode leading to the behavior of S/R.**	
72461 (c)	Type of behavior **In the two charts reviewed, the type of behavior was sufficiently documented.**	
72461 (c)	Length of time S/R applied **In both charts the length of time that S/R was applied was documented.**	
72461 (c)	Name of individual applying such measures **In both charts reviewed, the names of the individuals applying the measures were not present in the patient's health record.**	Ensure that the names of the individuals applying the restraints are present in the patient's health record.
72461 (b)	A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom S/R is ordered **The facility does not maintain a daily seclusion/restraint log**	Ensure that the facility develop and maintain a daily seclusion/restraint log.
CCR, T.22 72463(2) & 72463 (b) (1)	Patients placed in S/R shall be observed by qualified treatment personnel at least **every half hour.** This observation shall be noted and initiated in the patient's health record following each observation **In the 2 restraint charts reviewed, there was no documentation indicating the time the patient was removed from restraints (0232-2 and 0302-3). Staff reported that the patients in both charts were released from the restraints in less than half hour**	Ensure that there is chart documentation indicating the length of time patients are in restraints.

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
CCR, T. 22 72463 (a) 94 & 72463 (b) (3)	Opportunities for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which S/R is applied. **The staff reported that the patients in both charts were released from restraints in less than a half hour, not necessitating range of motion and exercise.**	
LADMH Policy 102.11	Toilet offered every 2 hours **According to staff, the patient in both charts were released in less than half hour, not necessitating toileting.**	
LADMH Policy 102.11	Restrained extremities should be examined for swelling and color change every 15 minutes **There was no chart documentation indicating if the restrained patients were examined for swelling and color change every 15 minutes in the 2 charts reviewed (0232-2 and 0302-3).**	Ensure that the patients are examined for swelling and color change every 15 minutes and that this is reflected in chart documentation.

Survey Focus Area: IMD SITE TOUR

STD. #	STANDARD/EVALUATION CRITERION	
T.22 73637(a)	Facility is **safe (no obvious hazards** present) **The facility appeared to be safe and there were no obvious hazards present.**	
T.22 72553(d)	**Emergency Evacuation Plan is posted** and fire/disaster/medical **emergency equipment** is in place to protect patients and staff. **The reviewers observed that the Emergency Evacuation Plan is posted and that the fire/disaster/medical emergency equipment is in place to protect the patients and staff.**	
T.22 72623 (2) (4)	Facility is **clean and sanitary**: Laundry Rooms; [vents safe] **During the site tour, the laundry room was observed to be clean and sanitary.**	
T.22 72343(a)	Dining Room/Kitchen; **During the site tour, the dining room and kitchen was observed to be clean and sanitary.**	
T.22 73637(a)	Activity areas; **During the site tour, the activity areas were observed to be clean and sanitary.**	
	Bedrooms; **The patients' bedrooms were observed to be clean, sanitary and comfortable.**	
"	Bathrooms in patient rooms; [exclude Tub/Shower Rooms] **The bathrooms in the patients' rooms were observed to be clean and sanitary.**	
	Medication Rooms. **The medication rooms were observed to be clean, sanitary and well organized.**	
WIC 5325. (b)	Patient **bathrooms** constructed to ensure **privacy**. [**Tub/Shower Rooms** have Privacy Curtains or Screens.] **The patient's bathrooms were observed to ensure privacy with privacy curtains.**	
	The facility provides: A **secure outdoor area** to all patients that allows access to fresh air, weather permitting (**exclusion**: attending verifies such access would place a patient or others in significant jeopardy); **The facility provided a secure outdoor area for each of the three units that allowed access to fresh air.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
T.22 72507 (b)	The facility shall provide designated areas for smoking **The facility has provided a designated area for smoking.**	
T.22 72507 (c)	The facility shall provide a designated area for non-smoking patients. Such a designated area shall be identified by a prominently posted "No Smoking " signs. **The facility has not provided a designated area prominently marked with an identifiable "No Smoking " sign.**	Ensure that an area is designated for non-smoking patients, and that a "No Smoking" sign prominently identifies this area.
T. 9 72527(a)(21), 72453(4)	Sufficient # of phones available for patient use in locations which ensure confidential conversations (clean/working) **The facility has sufficient number of phones (1 for each unit), which are clean, and in working condition. The location of the phones ensures confidential conversations. No patients complained of not having confidential conservations.**	
T. 9 72453(a)(1)	A **Canteen, shop, or vending machine** accessible to the patients or have other means of providing patients with the opportunity to purchase incidentals regularly. **The facility has a canteen that is accessible to the patients.**	
T. 9 72527(a)(21), 72453(a)(1)	The facility is in compliance with applicable statutes and regulations and Patients' Rights requirements, as evidenced by: Patients are able to **wear their own clothes;** **During the site tour, the patients were observed to be wearing their own clothes.**	
T. 9 72453(a)(5)	Access to **letter writing materials** (no facility letterhead) including stamps (available at nursing station) **The staff reported that the patients have access to letter writing materials including stamps. However, the materials were located in the Program Director's Office rather than at the nursing station where they would be more accessible to the patients.**	Ensure that the letter writing materials and stamps are available at the nursing station where they are more accessible to the patients.
	The following information shall be conspicuously posted in a prominent location accessible to the public	
	Posted **visiting hours** **The reviewers observed that the visiting hours were posted.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
T. 22 72503 (a) (3)	The current and following weeks menus for regular and therapeutic diets **The reviewers observed that the current and following week's menus for regular and therapeutic diets were posted.**	
T. 22 72503 (a)(2)	A listing of all services and special programs provided in the facility and those provided through written contracts. **The facility has provided a listing of all services and special programs in the facility and those provided through special contracts.**	
T. 22 72503 (a)(9)	A notice of the name, address and **telephone number of the District Office of the Licensing** and Certification Division, Dept. of Health Services having jurisdiction over the facility **The reviewers observed that a notice of the name, address, and telephone number of the District Office of the Licensing and Certification Division of the Department of Health Services having jurisdiction over the facility was posted.**	
CFR T. 42 Sec.483.10(7) iii	State Ombudsman **The reviewers observed that the State Ombudsman's poster was posted.**	
CFR T. 42 Sec.483.10(7) iii	Protection and Advocacy **The reviewers did not observe a poster from the Office of Protection and Advocacy.**	Obtain and post required information from the Office of Protection and Advocacy.
CFR T. 42 Sec.483.10(7) iii	The Medicaid Fraud control unit **There was no information posted anywhere in the facility to indicate whom to contact in cases of Medicaid fraud**	Ensure that there is information posted in the facility to indicate whom to contact in cases of Medicaid fraud.
T.22 72209	The **license** shall be conspicuously posted **The reviewers observed that the facility license is conspicuously posted in the facility lobby.**	
T22 There is no poster 72453 (a)	**Patients' Rights posters** prominently displayed in the predominant languages of the community (with 213 and 800 phone #s); **[at patient phones]** **The Patients' Rights posters were prominently displayed in English and Spanish, which are the predominant languages of the community.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
T.9 1810.360 (c)	Supply of **Complaint and Grievance Procedures Pamphlet** is available **The staff reported they have a supply of Complaint and Grievance Procedure Pamphlets. Additional pamphlets were delivered to the facility administrator on the first day of the site review (July 9, 2002).**	
WIC 5325 (i)	Supply of **Patients' Rights handbooks** **The staff reported they have a supply of the Patients' Rights Handbook.**	
CFR T.42 (pg 429) 483.10 (8)(i)(E)	Facilities provides and not charge for the following routine personal hygiene items and services including but not limited to hair hygiene supplies, combs, brush, bath soap, razor, shaving cream, toothbrush, toothpaste, dental floss, lotion, tissues, deodorant, etc. **According to the patients, the facility provided and did not charge for routine personal hygiene items and services.**	
T.22 72613 (a)	Each patient room shall be provided with a closet or locker space for clothing, toilet articles and other personal belongings **The reviewers observed that each patient's room had a closet/locker space for clothing, toilet articles and other personal belongings.**	
T. 22 72613 (b) (1)	A clean comfortable bed with an adequate mattress, sheets, pillow, pillow case and blankets, all of which shall be in good repair **The reviewers observed that the beds appeared clean and comfortable with adequate mattresses, sheets, pillows and blankets, all of which appeared to be in good repair.**	

Survey Focus Area: PATIENT INTERVIEWS-IMD

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
T.9 862 (b), WIC 5325 (i)	Patients received written information about Patients' Rights (handbooks) upon admission. **12 of the 18 patients interviewed reported receiving the Patients' Rights Handbook upon admission, 6 indicated they did not.**	Ensure that all patients are given the Patients' Rights handbook upon admission if this is not already being done.
T.22 72453 (a)(1)	Patients can wear own clothing: **Patients reported that they could wear their own clothing and were observed by the reviewers in their own clothes.**	
T.22 72453 (a)(2)	Provided with enough storage space **16 of the 18 patients interviewed reported that they have enough storage space. 2 indicated they did not.**	
T.22 72453 (a)(1)	Able to keep their own possessions, and/or personal belongings **All 18 patients interviewed reported they were able to keep their own possessions and personal belongings.**	
	Have access to stored possessions **All 18 patients interviewed reported they have access to personal belongings.**	
T.22 72453 (a)(4)	Patients should be able to use phones confidentially. **All 18 patients interviewed indicated they were able to use phones confidentially.**	
	Able to get change for the phone if they need to **13 of the 18 patients interviewed stated they could get change for the phones. Five reported they could not. All 13 who reported they could get change for the phones reported they could get it from the canteen.**	Ensure that patients are informed that change for the phones is available at the canteen if this is not already being done.
T.22 72453 (a)(3)	Allowed daily visitors without restriction **All 18 patients interviewed reported that they were allowed daily visitors without restriction.**	
WIC 5325(h)	Free to call the Patients' Rights Office **All 18 patients interviewed reported they were free to call the Patients' Rights Office.**	

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
T.22 72453 (a)(1)	To keep a reasonable sum of money **15 of the 18 patients interviewed reported they could keep a reasonable sum of money. Three reported that they could not. However, staff reported that these problems are usually due to benefits having not yet been approved and therefore the patient's personal allowance has not yet been received.**	Assist residents in obtaining their benefits in a timely manner, if this is not already being done.
	The patients get their incidental money regularly **15 of the 18 patients interviewed reported receiving their incidental money regularly. The 3 patients who did not appeared to be the same reason as above.**	Assist residents in obtaining their benefits in a timely manner, if this is not already being done
T.22 72453 (a)(1)	Are you able to spend your own money and is there a place to do so? **16 of the 18 patients interviewed reported that there was a place where they could spend their own money. Two patients reported not having a place to do so.**	Ensure that the staff inform the patients about the availability of the canteen as a place where they can spend their own money.
T.22 72527 (a)(10)	Patients have privacy when dressing and in using the bathroom and shower **17 of the 18 patients interviewed reported that they have privacy when dressing and in using the bathroom and shower. One patient said no. There was no specific reason offered.**	
T.22 72453 (a)(5)	Staff treats patients with respect. **16 of the 18 patients interviewed reported that the staff treated the patients with respect. 2 patients reported that they felt that the staff ordered them around.**	Ensure that staff treats all patients with respect.
T 9 865.2 (c)	Room or person searches are for good reason and the patients are given the option to be present during the search. **16 of the 18 patients interviewed reported that when their room was searched, it was for a good reason and they were given the option to be present. Two reported that their room had not been searched.**	.

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
WIC 5325.1(d)	The patients have had adequate and prompt medical treatment **16 of the 18 patients interviewed reported that they received adequate and prompt medical treatment. The remaining 2 reported that they did not require medical treatment.**	
	Do you have access to the **outdoors** (fresh air) regularly? **All 18 patients interviewed reported having access to the outdoors regularly.**	
WIC 5328	Patients' confidentiality is protected by staff. **All 18 patients interviewed reported that the staff protected the patients' confidentiality.**	
T.9. 1850.205(b)(2)	Patients are informed of their right to file a written grievance it they want to. **13 of the 18 patients interviewed reported that they have been informed of their right to file a written grievance. The remaining five patients reported they had not been informed.**	Ensure that all patients are informed of their right to file a written grievance.
T. 22 72613,72621	Patients are satisfied with the safety, cleanliness, and comfort of the facility **16 of the 18 patients interviewed reported they were satisfied with the safety, cleanliness and the comfort of the facility. One reported he was not but gave no specific reason. The last patient indicated there was, "a lot of fighting going on".**	Ensure that all precautions are taken to ensure patients' safety, if this is not already being done.
WIC 5325.1(e)	The opportunity to practice their religion if they want to **All of the 18 patients interviewed reported having the opportunity to practice their religion if they wanted to.**	

Survey Focus Area: Policy and Procedures

STD. #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
	Resident Consent for Medical Treatment This form states, " I,____give my permission to Foothill Health and Rehabilitation Center to treat me for any medical problem that I may have and any procedures necessary to maintain my health." **This is too general a release. The patient should have the ability to consent or not to consent to specific medical procedures as they occur, barring emergency situations.**	Discontinue having patients sign general medical release forms.
T. 9 865.2	Assault Precautions This policy's stated purpose is to "provide protection to staff and clients from those clients who have demonstrated assaultive behavior or who threaten to assault other persons." .Section 8 of this policy addresses visitors of patients on assault precautions. The policy states, "If visitors are allowed by attending physician, these visits are to be supervised". **Visitors can only be denied for good cause, which must be documented as a denial of rights. Therefore, the attending physician can only deny specific visitors for good cause and should not be allowing or not allowing visitors as a matter of policy.**	Amend facility's Assault Precaution policy to comply with California Code of Regulations, Title 9, Section 865.2.
T.9 865.5	Documentation of Denial of Rights **The policy does not include the requirement of documenting the date a specific right is restored.**	Amend Denial of Right policy to comply with California Code of Regulations, Title 9, Section 865.5.
T.22 72461 (b)	Use of Physical Restraint or Time-Out **This policy refers to "involuntary time-out" which is in fact seclusion. This policy should be rewritten as a Physical Restraint and Seclusion Policy.** **This policy does not include the requirement that the facility maintain a daily seclusion/restraint log as is required.**	Rewrite the, *Use of Physical Restraint or Time-Out Policy as a Use of Physical Restraint and Seclusion Policy.* Develop and maintain a daily seclusion/restraint log.

STD #	STANDARD/EVALUATION CRITERION	CORRECTIVE ACTION
County Policy: Personal Searches	Search Process **This policy states, "searches may be on a weekly basis as well as randomly" and "all residents who pass through the locked double doors will also be searched."** **Searches should be done only for good cause and not on a random basis.**	Amend the search policy so that searches are conducted only with good cause.

Ensure that the conservator signs application for voluntary treatment.

2. Ensure that the all applications for voluntary treatment are properly signed and dated.
3. Ensure that charts of all patients on private conservatorships contain the current conservatorship papers including documentation of powers.
4. Ensure that there is a Detain and Treat form or other documentation authorizing admission for each patient that has a Public Guardian.
5. Ensure all patients are evaluated by the physician as needed and at least every 30 days.
6. Ensure that all patients have a psychological evaluation within 45 days of admission.
7. Ensure all social work written assessments are completed within 5 days after admission.
8. Ensure that the care plan is updated each 90 days.
9. Ensure that a care plan is approved, signed and dated by the attending physician.
10. Ensure that the expected course of recovery is noted in all written aftercare plans.
11. Ensure that the after-care plan specifies the medications including side effects and dosages.
12. Ensure that all patients receive copies of the aftercare plan.
13. Ensure that all patients' guardians and/or conservators receive a copy of the aftercare plan.
14. Ensure that all patients are notified in writing of their rights within 24 hours of their admission, and that the rights notifications are dated.
15. Ensure that if a patient is receiving psychotropic medications and is on a conservatorship with powers to medicate, consent to medicate is provided by the authorized LPS conservator.
16. Ensure that there is a signed consent for each class of medication.
17. Ensure that all denials include a signature of the professional person authorizing the denial.
18. Ensure that there is documentation indicating the length of time the right is denied.
19. Ensure that there is documentation indicating the length of time the right is denied and ensure that a right does not continue to be denied when the good cause for its denial no longer exists, if this is not already being done.
20. Ensure that the names of the individuals applying the restraints are present in the patient's health record.
21. Ensure that the facility develop and maintain a daily seclusion/restraint log.
22. Ensure that there is chart documentation indicating the length of time patients are in restraints.
23. Ensure that the patients are examined for swelling and color change every 15 minutes and that this is reflected in chart documentation.
24. Ensure that an area is designated for non-smoking patients, and that a "No Smoking" sign prominently identifies this area.
25. Ensure that the letter writing materials and stamps are available at the nursing station where they are more accessible to the patients.
26. Obtain and post required information from the Office of Protection and Advocacy.
27. Ensure that there is information posted in the facility to indicate whom to contact in cases of Medicaid fraud.
28. Ensure that all patients are given the Patients' Rights handbook upon admission if this is not already being done.
29. Ensure that patients are informed that change for the phones is available at the canteen if this is not already being done.
30. Assist residents in obtaining their benefits in a timely manner, if this is not already being done.
31. Ensure that the staff inform the patients about the availability of the canteen as a place where they can spend their own money.
32. Ensure that staff treats all patients with respect.
33. Ensure that all patients are informed of their right to file a written grievance.
34. Ensure that all precautions are taken to ensure patients' safety, if this is not already being done.
35. Discontinue having patients sign general medical release forms.
36. Rewrite the, *Use of Physical Restraint or Time-Out policy* as a *Use of Physical Restraint and Seclusion Policy.*
37. Develop and maintain a daily seclusion/restraint log.
38. Amend facility's Assault Precaution policy to comply with California Code of Regulations, Title 9, Section 865.2.
39. Amend Denial of Right Policy to comply with California Code of Regulations, Title 9, Section 865.5.
40. Amend the search policy so that searches are conducted only with good cause.